Title: Establishing Community Health Teams to Support the Patient-Centered Medical Home
Section: 3502
State Option

Overview: Section 3502 of the Patient Protection and Affordable Care Act (ACA) establishes a federal grant program to assist with the development of community health teams that provide support to patient-centered medical homes (PCMH). Community health teams work with primary care practices as part of a PCMH, helping to coordinate care and provide access to a range of health services. If Nevada Medicaid pursues a PCMH initiative for people with chronic conditions (pursuant to Section 2703 of the ACA), the State may wish to apply for grant funding that may be available through Section 3502 to help establish community health teams to support providers in the establishment and operation of a PCMH.

Funds for this program may be used to support services and provide capitated payments to primary care providers, including obstetricians and gynecologists, that qualify as a PCMH. Primary care providers who participate in the program will be expected to furnish integrated and accessible health care. These practices will also be accountable for providing comprehensive personal health care needs while practicing in the context of family and community.

States, state-designated entities and tribal organizations are eligible to apply for this grant. Applicants must demonstrate plans for achieving financial sustainability within three years of receipt of the grant. Prevention initiatives and care management resources must be incorporated into the delivery of care. Services need to be integrated with community-based prevention and treatment resources.

Health teams must include an interdisciplinary, inter-professional team of health care providers that agree to provide services to eligible individuals with chronic conditions. The teams may include a variety of medical, behavioral, and alternative medicine practitioners. A provider who contracts with a care team shall: (1) provide a care plan for each patient; (2) provide access to participants' health records; and (3) meet regularly with the care team to ensure integration of care.

To obtain a grant or contract, a health team must:

- Establish contractual agreements with primary care providers for support services.
- Support patient-centered medical homes.

- Collaborate with local primary care providers and existing state and community-based resources to coordinate disease prevention and chronic disease management.
- Develop and implement interdisciplinary and inter-professional care plans with local health care providers.
- Incorporate health care providers, patients, caregivers, and authorized representatives in the design and oversight of the program.
- Provide coordination and support to local primary care providers so that they can provide access to high-quality health care services, preventive services, specialty care and inpatient services, culturally appropriate patient and family centered health care, and pharmacy services.

Support must be provided so that local primary care providers can:

- Coordinate complementary and alternative services.
- Promote strategies for treatment planning, as well as monitoring health outcomes and resource use, sharing information, and organizing care to avoid duplication of services.
- Provide local access to individuals implementing patient care.
- Collect and report relevant data that allows for evaluation of the success of the collaborative efforts on the patients' health.
- Establish a coordinated system of identification for children at risk of developmental or behavioral problems.
- Provide 24/7 care management and support during transitions in care settings (e.g., discharge planning and counseling support, referrals for mental health and behavioral health services).
- Serve as a liaison to community prevention and treatment programs.

The community health teams might provide support and establish contractual relationships with a number of physicians and or networks of providers, or could be established by a provider group to support their clinicians. Details on how the grant funding would support these health teams have not been established.

Targeted Population: The targeted population for Section 3502 would be same as the target population for Nevada's health homes project, if Medicaid chooses to pursue the establishment of a PCMH initiative. The target population consists of Medicaid recipients who have: (1) mental health condition or substance use disorder; (2) asthma; (3) diabetes; (4) heart disease; and/or (5) overweight, as evidenced by having a Body Mass Index (BMI) over 25.

In addition, recipients must meet one of the following criteria:

- Two chronic conditions;
- One chronic condition and at risk of developing a second chronic condition; or
- One serious and persistent mental health condition

Fiscal Impact: The ACA authorizes this program but does not appropriate any funding. As of October 1, 2010, CMS had not issued any guidance or provided additional information regarding this demonstration project. Until the specifics of this demonstration project are announced by CMS, and until Congress appropriates funding, the amount of federal funding is unknown, as are any state funding requirements.

Applicability to Nevada: Community health teams could provide supportive services to local primary care providers throughout Nevada. The lack of such a program may limit access to quality health care, including obstetrical and gynecological care, to individuals in the State. However, more information is needed to determine whether the State should apply for this grant, if and when federal funding becomes available.